DOCUMENT RESUME

ED 144 282 EC 102 218

TITLE	Therapy Services.
INSTITUTION	Austin Independent School District, Tex.
SPONS AGENCY	Office of Education (DHEW), Washington, D.C.
PUB DATE	76
NOTE	104p.; For related information, see EC 102 210 - EC 102 221
EDRS PRICE	MF-$0.83 HC-$6.01 Plus Postage.
DESCRIPTORS	Early Childhood Education; *Handicapped Children; *Occupational Therapy; *Physical Therapy; Program Descriptions; *Speech Therapy; *Therapy
IDENTIFIERS	*Austin Early Childhood Special Education Program

ABSTRACT

Reviewed are the goals and activities of the therapy services in the Austin Early Childhood Special Education Program. Specific sections detail activities for speech therapy (such as diagnostic assessment, habilitation, consultation, and reporting procedures), occupational therapy (including identification and assessment, and services to children, teachers, parents, support staff and other professionals), and physical therapy (including identification, assessment, habilitation and consultation services.) Appended in each section are sample forms, letters, and reports. (CL)

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The Austin Early Childhood Special Education Program

THERAPY SERVICES

Outreach Project
Austin Early Childhood Special Education
Austin Independent School District

Fall, 1976

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Overview

One important aspect of the "total child" approach taken by the Austin Early Childhood Special Education (AECSE) Program is the provision of speech, occupational, and physical therapy to its children. The services of two full time speech pathologists, two full time occupational therapists, and one part time physical therapist are required to meet the therapy needs of children in the program.

A child's specific therapy needs are determined through diagnostic assessment by each therapist, and a plan for direct or indirect therapy services is formulated in a diagnostic team meeting. Each child's therapy needs are different; he may require only one therapy service, or may need therapeutic intervention in all three therapy areas.

The speech pathologists are concerned with disorders or delays in speech, hearing, or language skills. Children receiving speech therapy services demonstrate difficulties in communication skills, expressive or receptive language, auditory reception, organization of thought and verbal processes, articulation skills, and/or oral motor functioning.

The occupational therapists serve children who have difficulties in the areas of fine motor skill development, sensory-motor

integration, self-help skills, normal reflex development, and/or perceptual-motor skills. Many children receiving occupational therapy services are physically handicapped and require programs designed to improve range of motion of limbs and/or provide othotic equipment such as hand splints.

The physical therapist provides services for children who have physical disabilities caused by disease or injury. Children receive physical therapy on the prescription of a physician, and their programs are designed to improve motility and increase independence.

Speech Therapy

Goals and Objectives

The primary goal of the speech therapy component is to meet the needs of each student in developing maximum competence in communication, relative to his overall development. In order to accomplish this goal, objectives and appropriate procedures for implementation of these objectives have been developed. These objectives are:

1. To provide early identification of students requiring speech, language and hearing services
2. To provide diagnostic assessment to determine the extent and nature of speech, language or hearing disorders
3. To provide habilitation to identified students
4. To provide year-end evaluation to measure child progress
5. To provide consultation to parents, teachers, support staff and other professionals
6. To provide referral and/or reporting services to other professionals and outside agencies
7. To maintain and use reporting systems necessary for program planning, management and evaluation
8. To provide additional support activities as necessary.

Activities

The bulk of the AECSE speech pathologists' time is spent in direct services to children in the program. They participate as necessary in the referral, screening, program definition, implementation, and evaluation/reporting phases of each child's program.

The flow chart (Figures 1-4 in Appendix A) represents a sequence of activities which encompasses the continuum of services provided. In the discussion that follows, reference will be made to the flow chart where appropriate. Numbers in parentheses refer to the corresponding flow chart box.

Early Identification of Students Requiring Speech, Language and Hearing Services

The speech pathologists may be involved in the referral process when a child visits AECSE before his actual entry into the program. During this preliminary screening (1), a gross estimate of speech/language functioning is obtained. Following the evaluation session, the speech pathologist gives immediate feedback to the parents concerning initial impressions of the child's functioning. Therapeutic intervention in another facility (private, community, or university speech center) may be recommended

as an interim measure before the child is able to enter the program or as an alternative to entry when the child's needs could be met in a regular preschool program, supplemented by speech/language therapy.

The speech pathologists may participate in the eligibility/ admission decision by making a judgment as to whether a child is eligible for the AECSE Program on the basis of a speech/ language handicap. Through membership on the placement committee (2), the speech pathologists assist other staff members in deciding which classroom a child will enter. Their recommendations here are based on knowledge of the current composition and functioning of the classrooms and any information they may have obtained during the preliminary screening.

As a child enters AECSE for the first time or re-enters at the beginning of a school year (3), the assessment process is begun. The first in a series of diagnostic decisions to be made is whether the child exhibits disordered or delayed speech/ language or whether his current functioning is adequate in relation to his overall development. This determination is a product of the procedures subsumed under the heading of initial assessment (4).

For children new to the program, the speech pathologist begins by reviewing information already accumulated from other agencies

and from parents. Pertinent background information and notes from initial classroom observation are recorded (see E. C. Speech/ Language History and Observation Record in Appendix A). Observation of each child in the classroom establishes initial impressions and indicates which, if any, formal screening measures are appropriate. Formal measures currently in use as screening instruments include the Preschool Language Scale, the Utah Test of Language Development, the Houston Test for Language Development, and the Verbal Language Development Scale. Informal assessment procedures provide supplemental information on every child and may be the only method possible for some, such as non-verbal children and those severely limited by maladaptive behaviors.

Paralleling this initial speech/language assessment, a hearing screening (5) is conducted to identify students whose hearing loss, whether transitory or permanent, may be contributing to a speech/language dysfunction. This audiometric data is viewed in terms of its implications for speech/language abilities and is a major consideration in the diagnostic decision-making process. Audiometric screening results and other initial assessment findings are shared with the AECSE teachers and support staff (see Appendix A for related hearing screening forms).

Diagnostic Assessment to Determine Extent and Nature of Speech, Language or Hearing Disorder

The preceding phase resulted in an adequate vs. disordered/delayed decision. Where screening procedures have provided sufficient information to make a judgement of adequate speech/language functioning, no direct intervention is provided (7). These children participate in general language development activities in the classroom and the speech pathologists are available on a referral basis if special problems arise. Further in-depth evaluation (6) is conducted for those students judged to exhibit disordered or delayed speech/language abilities to determine the exact nature and extent of their dysfunctions. For a small group of these children, the in-depth evaluation reveals that no significant problems exist, consequently the children are not scheduled for therapy services (7).

The in-depth evaluation encompasses the dimensions of language, hearing, articulation, structure and function of the peripheral speech mechanism, voice, rate and rhythm. Because independent functioning as well as academic learning is dependent upon the child's ability to understand spoken language and express himself verbally, language is the primary focus of evaluation and remediation. The complete language assessment considers the child's facility in:

1. Receiving the auditory signal (hearing acuity levels are obtained from the audiometric screening)
2. Discriminating the sounds and identifying their sequence
3. Deriving meaning from the message
4. Integrating the information with information previously received and stored (long and short term memory)
5. Recalling the information
6. Organizing the ideas of the desired output in a situation-appropriate manner
7. Formulating the output in terms of a correct sequence of linguistic structures and sounds.

Because a second major factor in effective communication is producing speech that others can understand, articulation adequacy is judged in terms of speech intelligibility, with consideration to factors such as speech sound discrimination, language-based articulation skills and oral motor functioning.

A variety of standardized measures are commonly used to assess these language and articulation parameters. However, due to the range of types and severity of problems within the early childhood population, no standard battery of tests is in use and much of the information may be obtained only through informal assessment and interaction. The tests currently in widest use for indepth evaluation purposes are the Developmental Sentence Types/Score

(standardized procedures for analyzing language samples), Test for Auditory Comprehension of Language, Assessment of Children's Language Comprehension, Northwestern Syntax Screening Test, Illinois Test of Psycholinguisitic Abilities, Arizona Articulation Proficiency Scale and Goldman-Fristoe Test of Articulation.

No formal instruments are available to assess the remaining dimensions of the indepth evaluation. The oral peripheral examination provides information concerning the integrity of the speech mechanism, its physical structure and muscular function for speech sound production and vegetative processes (chewing, swallowing, and sucking for saliva control and feeding). Dimensions of the voice evaluation include pitch, resonance, volume and quality.

The indepth evaluation yields a group of children who exhibit a range of disorders/delays and who require some type of speech/language intervention. Due to the numbers of children in the AECSE population found to require services, an alternative mode of service is consultation: a speech/language program is formulated by the speech pathologist, to be implemented by the classroom teacher.

The decision concerning the mode of service to be provided involves grouping students according to therapy priority. Students are prioritized according to case selection considerations which are: nature and severity of dysfunction in relation to overall

development, prognosis, age, language acquisition history, history of previous therapy and ability to respond to and benefit from intensive speech/language intervention (the latter involves cooperation, attention, motivation, learning rate and fatigue factors). The decision between regularly scheduled therapy and consultative service is made on an individual basis but is relative within the population. Constraints, such as limited time available for direct contact and the large numbers of children with severe communication dysfunctions, are imposed upon the scheduling decision so that the decision for each child is made with reference to the entire population.

Soon after a child has been evaluated, the speech pathologist attends an initial staffing (8) to share diagnostic findings to date in an effort to integrate information with other therapists, teachers, and the educational diagnostician or psychological associate. This may also be the time for participation in a staff decision as to whether the child demonstrates a significant handicapping condition, possibly a speech/language handicap.

In beginning the remediation process, initial diagnostic therapy sessions assist in formulating objectives for implementation in regularly scheduled therapy (9) (see Speech/Language Plan in Appendix A) with a correlated program of classroom goals (10) (see Classroom Supplement to Therapy in Appendix A). Alternatively,

a plan is formulated for teacher implementation (11) (see Therapy Services Log in Appendix A.) The classroom plans are presented and discussed at a staffing (12) and may require modification at later staffings.

As the final aspect of the program definition phase, parents are included as an important part of the remediation process. Structured home programs (13 and 14) are provided, especially for the parents of children who require and are receiving extensive remediation (13). An initial parent conference (15) is held, either in conjunction with the classroom conference or on a separate occasion, to discuss results and implications of the diagnostic assessment and to present a home program (see Therapy Report to Parents in Appendix A). To assist in implementation of the home program, the speech pathologist may invite the parent to attend demonstration therapy, and all parents are encouraged to observe sessions whenever possible (20).

Habilitation of Identified Students

For children receiving direct intervention, the implementation phase consists of attending regularly scheduled therapy sessions (16). Due to attention factors and the severity of involvement, most children are scheduled individually, although a few group sessions (2 children) are possible. Depending upon the child's tolerance

for structured interaction, the sessions last up to 30 minutes.

AECSE teachers implement the classroom plans for children receiving consultative service (17). These teacher-implemented programs may be broad or highly specific depending upon the scope of the problem. A total remediation program may include cooperation with the occupational therapist in a feeding program.

In order to monitor these classroom plans, a two-hour period is set aside each week for classroom observation, individual contact and/or further testing (18). This time is also used for classroom observation of children who are in therapy to ensure relevant therapy goals, to facilitate carryover of therapy behaviors, and for testing when a large block of time is required. Finally, in addition to the on-going evaluation of children receiving services, this time is used for screening and diagnostic evaluation of children who enter the program after the beginning of the school year. Such children often enter the program for diagnostic purposes only.

An additional aspect of the on-going evaluation is the exchange of information with teachers, other therapists and support personnel in staffings (19). At this time, the speech pathologist may summarize therapy progress, share diagnostic information, serve as a consultant for classroom planning and obtain other information to incorporate into the total view of the child and his needs.

Year-end Evaluation to Measure Child Progress

While therapy, classroom activities, and staffings continue through the entire year, end-of-the-year evaluation (21) must begin in early spring due to the large numbers of children involved. This post-assessment is most formalized for those children who have been in therapy and are leaving the program (due to age or other considerations), although all children who are leaving and all who have received consulatative services receive some degree of speech/language assessment.

After post-assessment data has been assembled, the speech pathologists attend Admission, Review, and Dismissal Committee meetings (22) to participate in decisions concerning the most suitable instructional arrangements for the following school year for children not returning to AECSE. Information concerning major communication deficits and estimates of language age functioning are frequently crucial factors in the consideration of a child's future placement. This information, in addition to relevant history, behavioral observations, test interpretations and a summary of therapy and progress, is compiled in comprehensive final reports (23) (see Final Speech, Language and Hearing Summary in Appendix A) which are included in the AECSE psychological report and passed on to receiving therapists, teachers and other staff. A progress report (24) (see AISD Disposition Report in Appendix A)

is written for children who received services but will return to AECSE the following school year.

Progress and a report of current functioning is again shared with parents at a final parent conference (25). The speech pathologist may make suggestions or write a program for home stimulation during the summer vacation or may assist the parent in obtaining alternate therapy services during the school interim period.

Consultation to Parents, Teachers, Support Staff and Other Professionals

Parent Consultation

Parents are scheduled for classroom and/or therapy conferences where the speech pathologist's diagnostic information and planned therapy objectives are shared in detail. Parents are invited and scheduled to observe therapy and to discuss the student's progress on an ongoing basis. Efforts are made through personal contacts to involve the parent in the student's therapy program by providing individualized, written suggestions.

Parent training is accomplished on a group or individual basis. Parent workshops, conducted in large groups, emphasize such topics as normal acquistion of speech and language development or may provide opportunities for general discussion sessions. Carry-over and reinforcement of therapy targets is maximized when the parent is involved in learning specific techniques to be utilized

in a structured interaction.

Teacher Consultation

Consultation with teachers is ongoing and focuses on three major areas: providing diagnostic information and impressions, assisting in formulating and modifying educational plans, and conducting teacher training through demonstration and/or inservice training sessions. Verbal and/or written suggestions designed to implemented by the teacher are explained, modified and discussed in staffings or informal meetings. Teachers are encouraged to observe therapy sessions conducted in both the therapy room and classrooms to facilitate learning therapeutic techniques.

Support Staff Consultation

Services are provided to support staff on two levels: individual children and program decision making. The speech pathologists provide complete diagnostic and progress reports on individual children to the educational diagnostician and psychological associate for inclusion in the psychological report. Responsibility for assessing the child's language and functioning levels and their effects on demonstrated intellectual functioning (psychological testing) is assumed by the speech pathologists. Recommendations regarding placement outside AECSE, projected instructional needs and therapeutic intervention are made as needed. Judgements and

impressions regarding eligibility and placement of referred children with communicative disorders are provided by the speech pathologists in informal and formal committee meetings. The speech pathologists assist in planning and modifying program procedures for screening, assessment, staffing, record keeping and evaluation.

Contributions in the form of articles or suggestions are made to the program newsletter written by the parent coordinator. Parent workshops, planned and conducted by the speech pathologists, are scheduled by the parent coordinator.

Interaction with the coordinator of community services revolves primarily around follow-up for children failing hearing screenings. The speech pathologist informs the coordinator of a child's failure (type and degree) and completes the forms necessary to inform the child's parents and/or physician. These forms are sent by the coordinator who aids the parents in obtaining financial or transportation assistance. Information regarding medical intervention or further audiological evaluation is recorded by the speech pathologists and the coordinator of community services. The speech pathologist identifies other medical needs of a child, such as dental care or examination by a specialized team (e.g. cleft palate children), and requests assistance from the coordinator in obtaining these services for the child.

Occupational Therapy and Physical Therapy Consultation

The speech pathologist frequently confers with other therapists and works with them to plan coordinated programs, such as developmental feeding. Sharing diagnostic information, therapy plans parent home programs and approaches to skill development in children are primary activities.

Referral and/or Reporting Services to Other Professionals and Outside Agencies

Requests for information and recommendations regarding a child's hearing, speech and language abilities come from a variety of sources including physicians, dentists, audiologists, other speech pathologists and other programs delivering services to AECSE children. The speech pathologist refers, assists in planning, maintains contact and engages in follow-up activity for children requiring or receiving services from these professionals. Conferences, telephone contacts, and reports are primary avenues of communication.

Maintain and Use Reporting Systems Necessary for Program Planning, Management and Evaluation

Record keeping procedures have been developed to permit the acquistion of current information at program and case management levels. Individual folders of children enrolled in therapy are

maintained in accordance with state and district guidelines which document the child's need for speech therapy and the plan by which he has received such service. Contents of these folders include: hearing, speech, and language screening data, test protocols, evaluation materials, therapy plan and progress reports, programs written for teachers and parents, pertinent reports received from other agencies or professionals, and state and district forms (see Appendix A for related forms). A complete record of program wide hearing screening results and follow-up is also maintained. Additionally, the speech pathologist completes reporting forms, such as statistical records and pupil accountability, as required by state or district policies.

Provide Additional Support Activities as Necessary

The speech pathologists, as members of both the AECSE staff and district speech/language services staff, attend and participate in various committee meetings and conduct inservice training programs for both groups. In addition, speech pathologists provide a variety of support services to AECSE personnel. As a vehicle for improving professional interaction, the speech pathologists assume supervisory roles in accepting student clinicians from the University of Texas on a one semester basis.

Appendix A

Figure 1

REFERRAL AND SCREENING

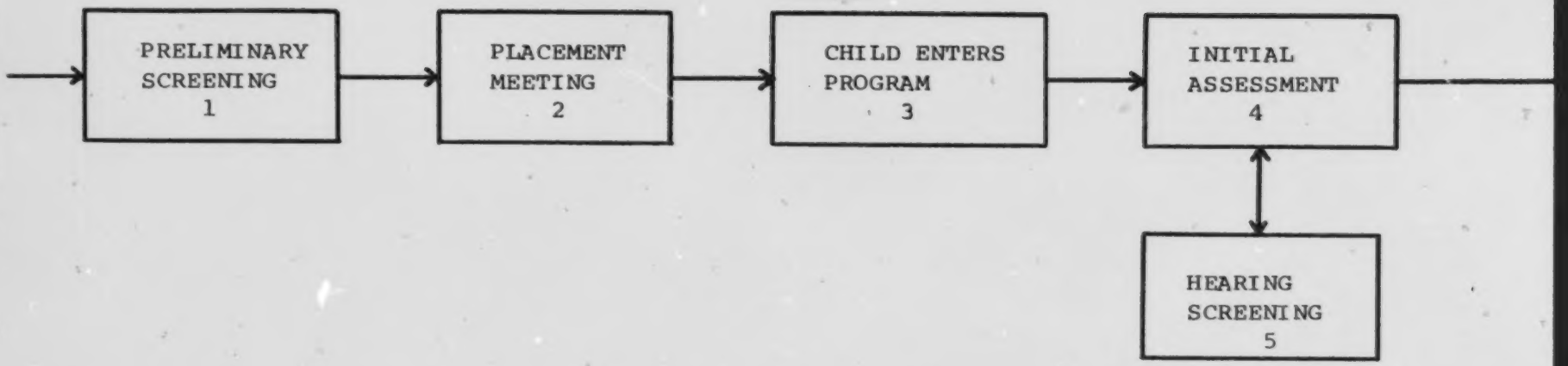


Figure 2

PROGRAM DEFINITION

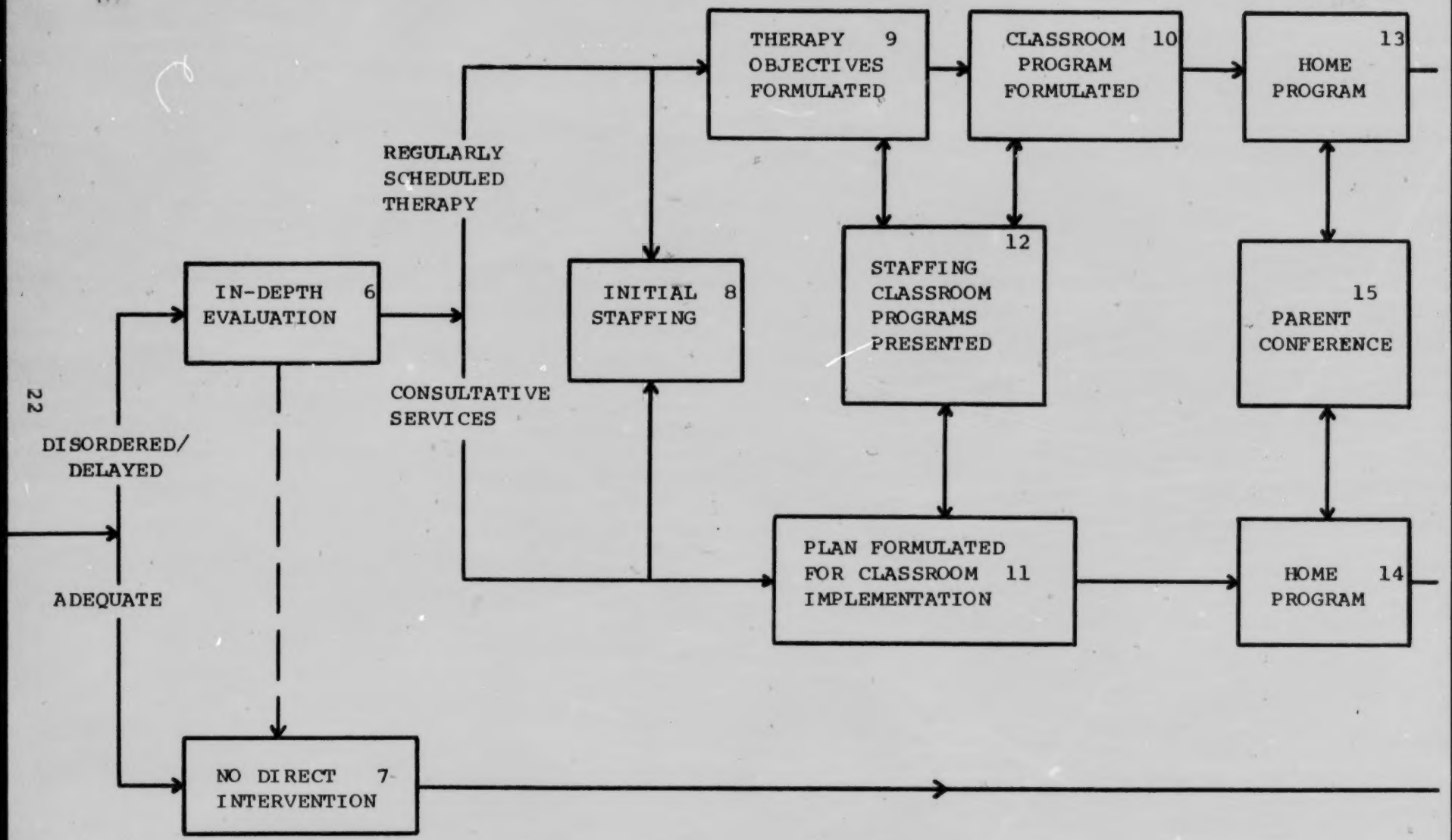


Figure 3

IMPLEMENTATION

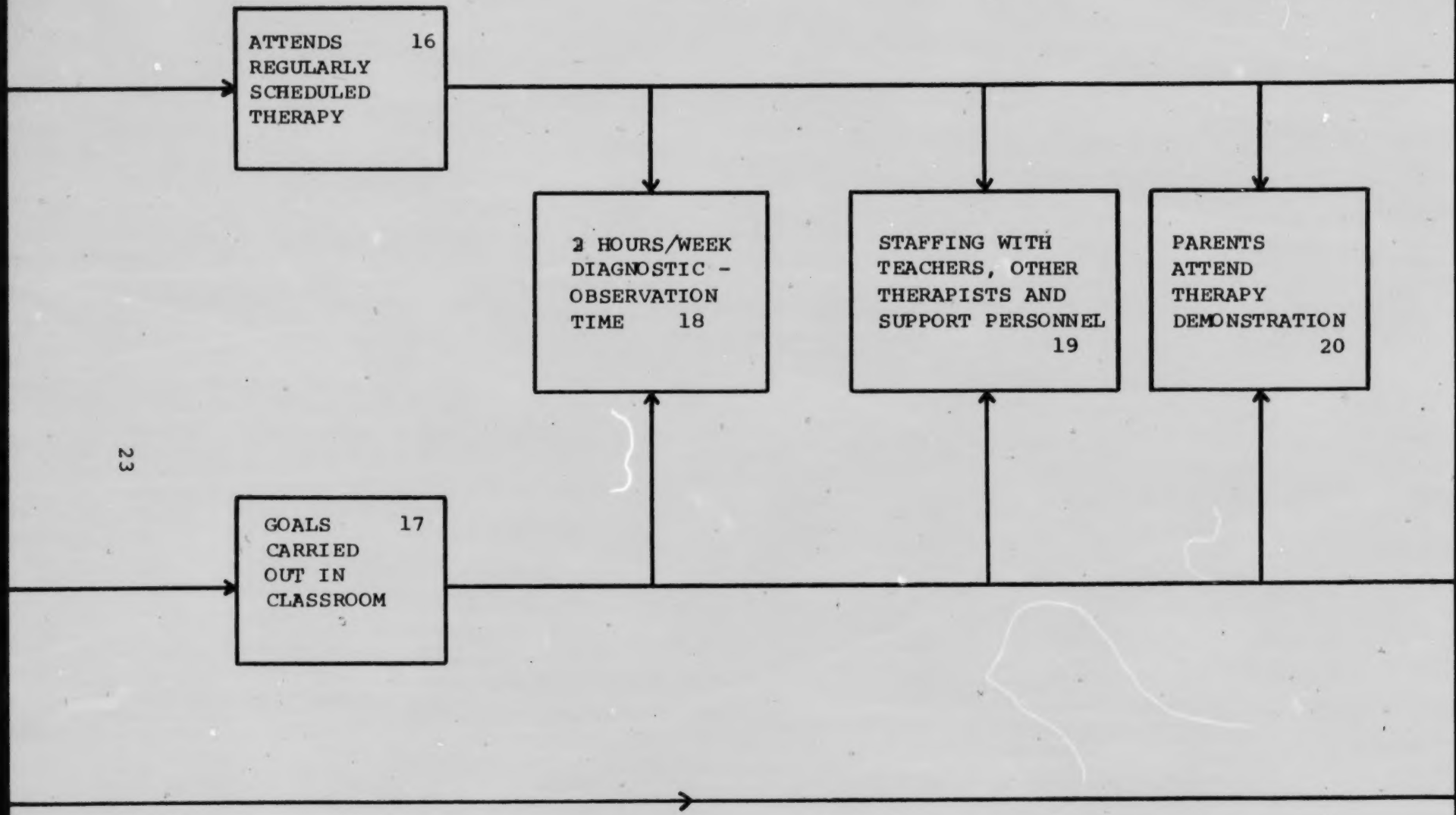
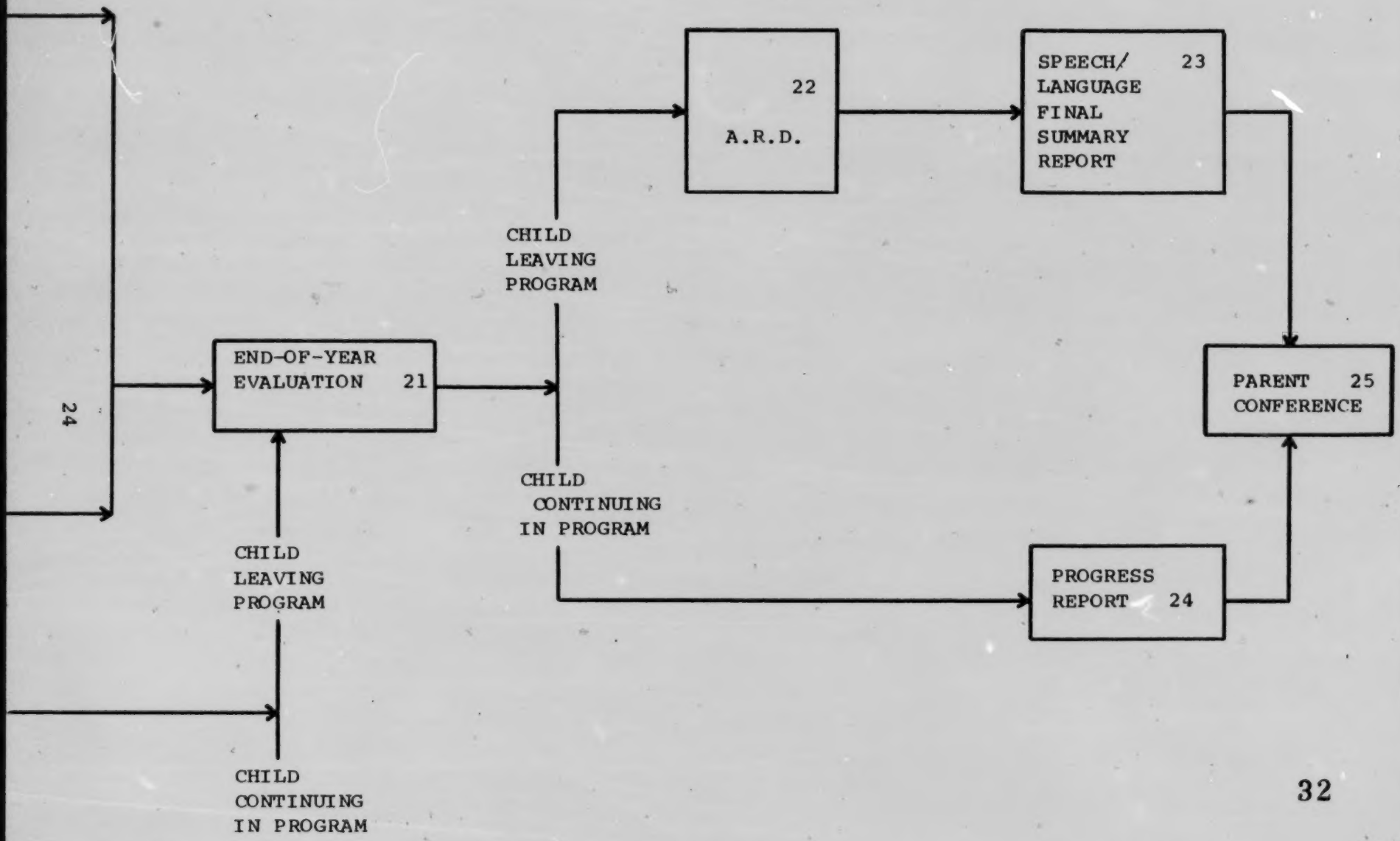

ATTENDS REGULARLY SCHEDULED THERAPY 16
2 HOURS/WEEK DIAGNOSTIC - OBSERVATION TIME 18
STAFFING WITH TEACHERS, OTHER THERAPISTS AND SUPPORT PERSONNEL 19
PARENTS ATTEND THERAPY DEMONSTRATION 20
GOALS CARRIED OUT IN CLASSROOM 17

Figure 4

EVALUATION/ REPORTING



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E. C. SPEECH/LANGUAGE HISTORY AND OBSERVATION RECORD

NAME:_____ DATE ENTERED:_____

D.O.B.:_____ REFERRED BY:_____

CLASSROOM:_____ DATE OBSERVED:_____

PERTINENT HISTORY (from folder):

TEACHER COMMENTS:

SPEECH OBSERVATIONS:

Articulation: Sound errors occasionally noticed _____
Speech is intelligible but noticeably in error_____
Speech is intelligible with careful listening_____
Speech is unintelligible _____

Oral mechanism: Teeth _____ Tongue_____
Palate/movement_____
Chewing_____ Swallowing_____

Voice: Adequate_____ Hypernasal _____ Denasal_____
Intensity_____
Phonation_____
Pitch_____

Rate/Rhythm: _____

HEARING:

Response to sounds:_____

INITIAL BEHAVIORAL AND LANGUAGE OBSERVATIONS:

SUMMARY OF OBSERVATIONS/RECOMMENDED FOLLOW-UP:

Austin Independent School District
Early Childhood Special Education
Hearing Screening Record
School Year _____

Name _____

DATE	Initial screening		Re-test		Re-test		Re-test	
	R	L	R	L	R	L	R	L
Passed screening bilaterally:								
Failed:								
Pure tone								
Impedance								

Follow-up: _____

_____

_____

_____

_____

_____

_____
Speech Pathologist

Key:
Failures: NM= Non-medical M= Medical

Austin Independent School District
Early Childhood Special Education

_____

Dear Parent,

_____ hearing was tested today and we are happy to inform you that our results indicate normal hearing at this time.

Sincerely,

Speech Pathologist

Austin Independent School District
Early Childhood Special Education

_____

Dear Parents:

_____ was recently seen for a routine hearing screening at school. Test results indicated that his hearing was not normal at this time and that further testing will be needed. Please contact _____, Audiologist, at _____ as soon as possible to schedule an appointment for a complete hearing evaluation.

In addition, please contact _____, Coordinator of Community Services, at 474-6461, to notify her of the date of your appointment and to discuss any questions you may have regarding the evaluation.

Sincerely,

Speech Pathologists

Austin Independent School District
Early Childhood Special Education

_____

Dear Parents:

_____ was recently seen for a routine hearing screening at school. The results of this examination indicated that his hearing was not normal at this time and that a medical examination by an ear specialist is needed. When you have arranged an appointment, please contact _____, our Community Services Coordinator, at 474-6461 to tell her the date and doctor so that we can send our screening results to the physician prior to your visit.

If you have any problems related to arranging this medical examination for your child, please contact _____ immediately.

Sincerely,

Speech Pathologists

AUSTIN INDEPENDENT SCHOOL DISTRICT
Early Childhood Special Education
Casis Elementary School
2710 Exposition Blvd.
Austin, TX 78703

_____

Dear Doctor:

_____, who attends the Early Childhood Program, was screened for hearing on _____ by _____ _____, Audiologist. The results indicated that a medical exam is needed. The parents have been notified and we understand that _____ has an appointment with you on _____.

For your convenience we have enclosed our screening information and ask that you complete this form and return it to us for our records.

Thank you in advance for your cooperation.

Sincerely,

Speech Pathologists

OTOLOGY REFERRAL

Austin Independent School District
Department of Special Education
Early Childhood Program

Name_____ Age _____

Date _____ Parents_____

Reason for referral:

Medical Examination Results:

Follow-up Plan:

_____
Physician's Signature

_____
Date of Examination

****Please return form to:

Speech Pathologists
Casis Elementary School
Early Childhood Program
2710 Exposition Blvd.
Austin, TX 78703

HEARING SCREENING RESULTS

CLASSROOM:_____

DATE:_____

RESULTS

NAME	R	L	FOLLOW-UP*

*Follow-up Key:

O - Referred to Otologist, medical problem suspected

C - Will be seen at C.A.R.C. for further testing (non-medical fail)

SPEECH/LANGUAGE PLAN

Name _____

1. Diagnostic information:

2. Speech/Language sample:

3. Description of the problem:

4. Behavioral observations:

5. Goal:

6. Learner-process objectives:

7. Evaluation:

8. Follow-up:

Austin Independent School District
Early Childhood Special Education
Classroom Supplement
to Therapy

School Year _____

Speech Therapy

Therapist:

Occupational Therapy

Child's Name:_____

Austin Independent School District
Early Childhood Special Education
Therapy Services Log
School Year _____

Speech Therapy

Therapist:

Occupational Therapy

Child's Name:_____

Services Provided:_____

Date Summary of Diagnostic:

Goals:

Recommendations to teachers:

Austin Independent School District
Early Childhood Special Education
Therapy Report to Parents

Therapist:_____

Date:_____

Child's Name:_____

Follow-up:

AUSTIN INDEPENDENT SCHOOL DISTRICT
EARLY CHILDHOOD SPECIAL EDUCATION

FINAL SPEECH, LANGUAGE AND HEARING SUMMARY

NAME:_____ DATE:_____

D.O.B.:_____ EXAMINER/THERAPIST:_____

TYPE OF SERVICE PROVIDED:

PERTINENT HISTORY:

STANDARDIZED TESTING (list):

AUDIOLOGICAL DATA:

Passed screening bilaterally: yes ___ no___ (explain below)

INTERPRETATION OF TESTS AND OBSERVATIONS:

SUMMARY OF THERAPY AND PROGRESS:

RECOMMENDATIONS:

____ CONTINUE IN THERAPY PROGRAM

____ RECOMMEND EVALUATION AND/OR CONSULTATION BY A SPEECH PATHOLOGIST AT THE BEGINNING OF THE NEXT SCHOOL YEAR

____ DISMISSED FROM THERAPY PROGRAM

____ OTHER SPECIFIC RECOMMENDATIONS:

_____

SPEECH PATHOLOGIST,
AUSTIN EARLY CHILDHOOD
SPECIAL EDUCATION

AUSTIN INDEPENDENT SCHOOL DISTRICT
Department of Special Education
Speech Therapy
Disposition Report

Date _____

Name _____ School _____

Age _____ Unit/Grade_____ Teacher_____

Communication Disorder_____

Summary of therapy and evaluation of progress:

Disposition:

_____ Dismissed from the therapy program.

_____ Continued in the therapy program.

_____ Moved out of Austin.

Therapist_____

PP362(Revised 1973)

Occupational Therapy

Goals and Objectives

In an early childhood setting, the occupational therapists evaluate specific areas of growth and development and/or disease processes and then provide a therapeutic intervention program through direct therapy and/or consultative services to teachers and parents. The role of AECSE occupational therapists can be described by the following objectives:

1. To identify and assess children requiring occupational therapy services
2. To provide services to children identified as needing occupational therapy intervention
3. To provide end-of-year evaluation of child progress
4. To provide services to teachers
5. To provide services to parents
6. To provide services to support staff
7. To provide referral and/or reporting services to other professionals and outside agencies
8. To record and maintain pertinent program information.

Activities

The occupational therapy component of the AECSE Program is an integral part of the services provided to AECSE children. Two full time occupational therapists are employed by the program and providing services to children demands most of their time.

As on-call members of the assessment team, the therapists are involved as needed in referral and screening activities; subsequent involvement in program definition, implementation and evaluation activities occur only in cases of children who receive direct services from the occupational therapists.

The occupational therapy services flow chart (Figures 5-8 in Appendix B) outlines the sequence of occupational therapy services from preliminary screening to final report. The numbers in parentheses in the following sections refer to the appropriate boxes in this flow chart.

Identification and Assessment of Children

The occupational therapist's initial contact with a child occurs during the referral phase. She participates in preliminary screening (1) to determine eligibility where a physical or motor problem is suspected. Because of her involvement with each classroom, she also assists in making placement decisions based on information from the preliminary screening and her knowledge of

each classroom's composition. Following the placement committee meeting (2) and the child's entrance into the program (3), initial assessment (screening) activities begin (4).

During the screening phase the therapist attempts to determine if the child has a need for occupational therapy. Initial assessment activities include:

1. Observation of the child's classroom and/or playground performance
2. Informal evaluation using the Occupational Therapy Evaluation form (see Appendix B)
3. Review of the child's folder, paying particular attention to any recommendations for therapy or occupational therapy reports from other agencies.

Specific areas screened are: gross motor development, fine motor development, perceptual-motor abilities, self-help skills, sensory-motor integration, and reflex maturation.

Based on screening information, the therapist determines whether the child requires therapy. In many cases an indepth evaluation (5) is necessary to determine the nature and severity of suspected problem areas. The evaluation may include the following tests: The Ayres Southern California Sensory-Integration Battery, the Frostig Developmental Test of Visual Perception, and the Goodenough Draw-A-Man Test. Further clinical observations

are made to assess the child's motor development, reflex maturation (see the Reflex Testing Chart in Appendix B), and specific sensory motor integration problems such as tactile defensiveness or postural insecurity. The results of such an evaluation may indicate that the child needs no occupational therapy services at the present time (6), either because a suspected problem does not exist or because it is not a significant problem.

Provision of Services to Children

Service Determination and Scheduling

If a child requires therapy, the decision of how to best provide services is made following the initial assessment. The service alternatives are regularly scheduled therapy for the child or consultative services to his teacher. The decision whether to provide regularly scheduled therapy or consultative services is made based on the following considerations:

1. The nature and/or severity of the determined problems
2. The child's ability to cope with and benefit from an intensive therapy situation
3. Previous occupational therapy received (either from a previous year in the AECSE Program or from an outside agency)
4. Specific recommendations from a physician
5. Amount of therapist time available for direct therapy.

The AECSE occupational therapists have found that to ensure quality treatment a regularly scheduled case load should not exceed 15-18 children. There is also an inherent limitation as to how many children can receive regularly scheduled therapy due to the limited time available in the 4½ hour school day.

The therapists schedule a two hour-a-week period solely for diagnostics/observation. This time is used to:

1. Test new children entering the program
2. Test children in the regular therapy program when the test to be administered requires more than the 30 minute therapy session
3. Observe the classroom implementation of the written therapy program
4. Re-evaluate the children served on a consultative basis
5. Schedule parent training and demonstrate therapy techniques.

Therapy Services

The children who participate in regularly scheduled therapy receive a direct intervention program. These children are scheduled several times per week for thirty minute sessions, and supplemental classroom programs are provided for their teachers. Most children are seen individually, but small groups are also arranged. Before the child can be scheduled for therapy, the parents receive a letter

(see Appendix B) explaining the child's therapy needs. The letter includes a Referral for Treatment in Occupational Therapy form (see Appendix B), which must be completed by a physician and returned to the therapist.

The objectives for the children receiving direct therapy depend upon the nature of their handicaps but may include the following:

1. To increase or maintain strength, endurance and/or range of motion
2. To provide or recommend adaptive or orthotic equipment (such as hand splints, lapboards, overhead slings, wheel chair modifications)
3. To remediate perceptual-motor problems
4. To improve independence in self-help areas (dressing, feeding, grooming)
5. To enhance gross and fine motor development
6. To normalize reflex maturation (diminish primitive or pathological reflexes and facilitate development of more mature reflex responses)
7. To provide developmental stimulation (general visual, tactile, kinesthetic, vestibular stimulation to enhance the child's awareness of self and environment)

8. To enhance sensory-motor integration by providing specific activities designed to influence integration.

A child with moderate problems which require some type of therapy services but not scheduled for direct therapy services will be served mainly through consultation provided to his classroom teacher. This consultation is based on the information obtained from the initial indepth evaluation and periodic re-evaluation and is provided to the teachers through staffings and written classroom recommendations (see Therapy Services Log in Appendix B).

A treatment plan (7) is formulated for the child who is regularly scheduled for therapy. The treatment plan specifies the goals of therapy and is based on the information obtained from the initial assessment, indepth evaluation, and clinical and classroom observations.

During the initial staffing (8) the information gathered for both the children in regularly scheduled therapy and those who receive consultative services through a classroom program is shared with the classroom teacher and support staff. Therapist participation at this time involves sharing pertinent information about the child and assisting in the admission decision.

A written program for classroom implementation (9,10) is developed and presented at a later staffing. These programs are more "therapy oriented" for the children receiving regularly

scheduled therapy (see Classroom Supplement to Therapy in Appendix B) and more general for the children whose teachers receive consultative services (see Therapy Services Log in Appendix B). A time is often scheduled for the teacher to observe the child in therapy (14) and to be trained to carry out specific therapeutic techniques. Classroom programs implemented by the teachers (15) are monitored and modified by the occupational therapist during staffings (17).

Home Programs

A home program for the parents is developed and written for all children receiving occupational therapy (11, 13). During the pre-parent conference (12) the home programs are discussed with the teachers and support staff. At this time the therapists share the information that will be presented to the parents.

During the parent conference (15) the occupational therapist reviews the diagnostic information and testing results and presents the home program (see Therapy Report to Parents in Appendix B). A separate occupational therapy conference is held when the therapist feels it is required. If specific therapeutic techniques are included in the home program, a time is arranged to demonstrate the child's therapy program and to instruct the parents in using the techniques (18). Parents are encouraged to observe therapy throughout the school year.

End-of-Year Evaluation of Child Progress

The end-of-year evaluation/reporting phase (19) begins in April. During this phase program implementation continues. Post-evaluation is conducted if a child is leaving the AECSE Program and/or has received some form of occupational therapy during the school year. It involves an assessment of each child's progress in his problem areas.

The information obtained from the post-evaluation is shared at Admission, Review, and Dismissal Committee meetings (20). In such meetings, the therapist participates in the placement decision and provides recommendations for continued therapy. A progress report (22) is written for each child continuing in the program who has received regularly scheduled therapy. This report is included in the child's main folder. If the child is leaving AECSE the therapist's final report (21) is included in the psychological report and in the out-going main folder.

An end-of-year parent conference (23) is held at which time the therapist shares the post-evaluation information and recommendations for therapy.

Provision of Services to Teachers

The occupational therapist provides services to teachers in a variety of ways. The major service is that of a consultant. The consultant approach facilitates a team effort in providing a

comprehensive program for the child. Another reason for consultation is that the number of children requiring intervention from an occupational therapist (approximately 90%) is larger than the number of children to whom two therapists can effectively provide direct therapy.

The activities of the therapist as a consultant include the following:

1. Informing teachers of what is done in therapy
2. Providing diagnostic information on specific children
3. Making recommendations for classroom implementation
4. Training teachers to carry out specific therapeutic recommendations with supervision
5. Answering any questions teachers may have relating to occupational therapy services.

These activities are implemented by holding inservice training sessions and workshops, sharing diagnostic information at staffings, providing a written occupational therapy classroom program, demonstrating therpeutic techniques, and providing reading materials pertaining to specific disorders or diseases.

These consultation services also provide the therapist with a working knowledge of the child's present classroom functioning: the therapist attends weekly staffings with the teachers where she participates in discussions of the child's progress.

Provision of Services to Parents

The occupational therapist provides services to parents in a variety of ways, the major emphasis being to aid the parents in understanding their child's problems and then to provide a means for them to help him progress at home.

The objectives for parent services are as follows:

1. To assist the parents in understanding their child's problems and the implications of these for his educational future
2. To help parents realize their critical role as facilitators in the development of functional skills in their child
3. To provide information to parents concerning specific disorders and normal development
4. To provide specific home programs for parents to implement
5. To share diagnostic information and therapy progress with parents.

These objectives are met via workshops, demonstrations of therapy, written individual home programs, parent conferences, and newsletters.

Provision of Services to Support Staff

Many of the children scheduled for occupational therapy also receive speech therapy and/or physical therapy. To provide a team

approach, it is necessary to share diagnostic information and its implications with each speciality. The occupational therapist provides 1) pertinent information concerning the child's functional level and 2) diagnostic information which is valuable in determining eligibility and placement of the child in the AECSE Program. The therapist also works as a team member with other support staff and provides written therapy reports to the diagnostician and psychological associate to be included in the child's psychological report.

The therapist supplies articles to the parent coordinator for use in the parent newsletter and makes recommendations as to particular parents requiring the services of the parent coordinator. The therapist may also inform the coordinator of community services of a child's needs for services provided by individuals in the community.

Provision of Services to Other Professionals and Outside Agencies

The occupational therapist may have contact with professionals and agencies in the community for a variety of reasons. A common practice is to send a progress report on a given child to the physician who referred that child for occupational therapy. Recommendations for occupational therapy services are made to parents of children leaving the program, and reports are sent to the receiving therapist at the child's new placement.

Frequently, the occupational therapists are asked to assess

and work with children from other schools. In most cases the child is evaluated and diagnostic information and recommendations are shared at the Local Support Team meeting in the school.

Recording and Maintaining Pertinent Program Information

The therapist maintains a folder for each child she serves. Included in each folder are reports from other agencies serving the child previously, testing results, pertinent sample descriptions of the child's performance, copies of the child's classroom program and the parent home program, and the physician's referral on the child.

Appendix B

FIGURE 5

REFERRAL AND SCREENING

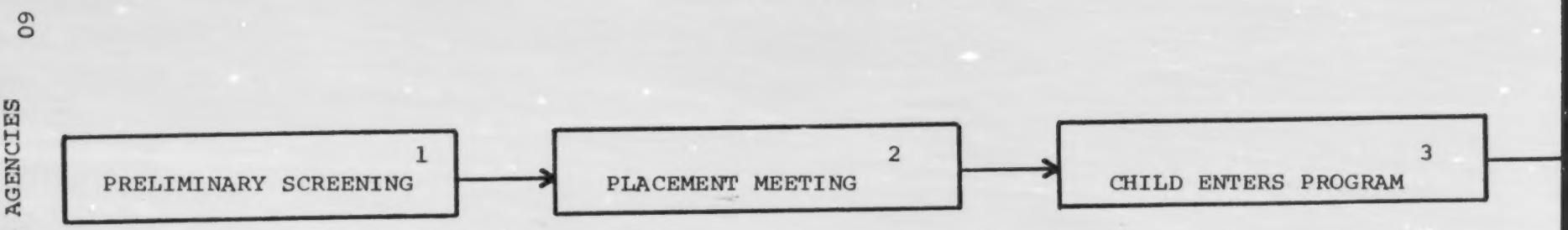


FIGURE 6

PROGRAM DEFINITION

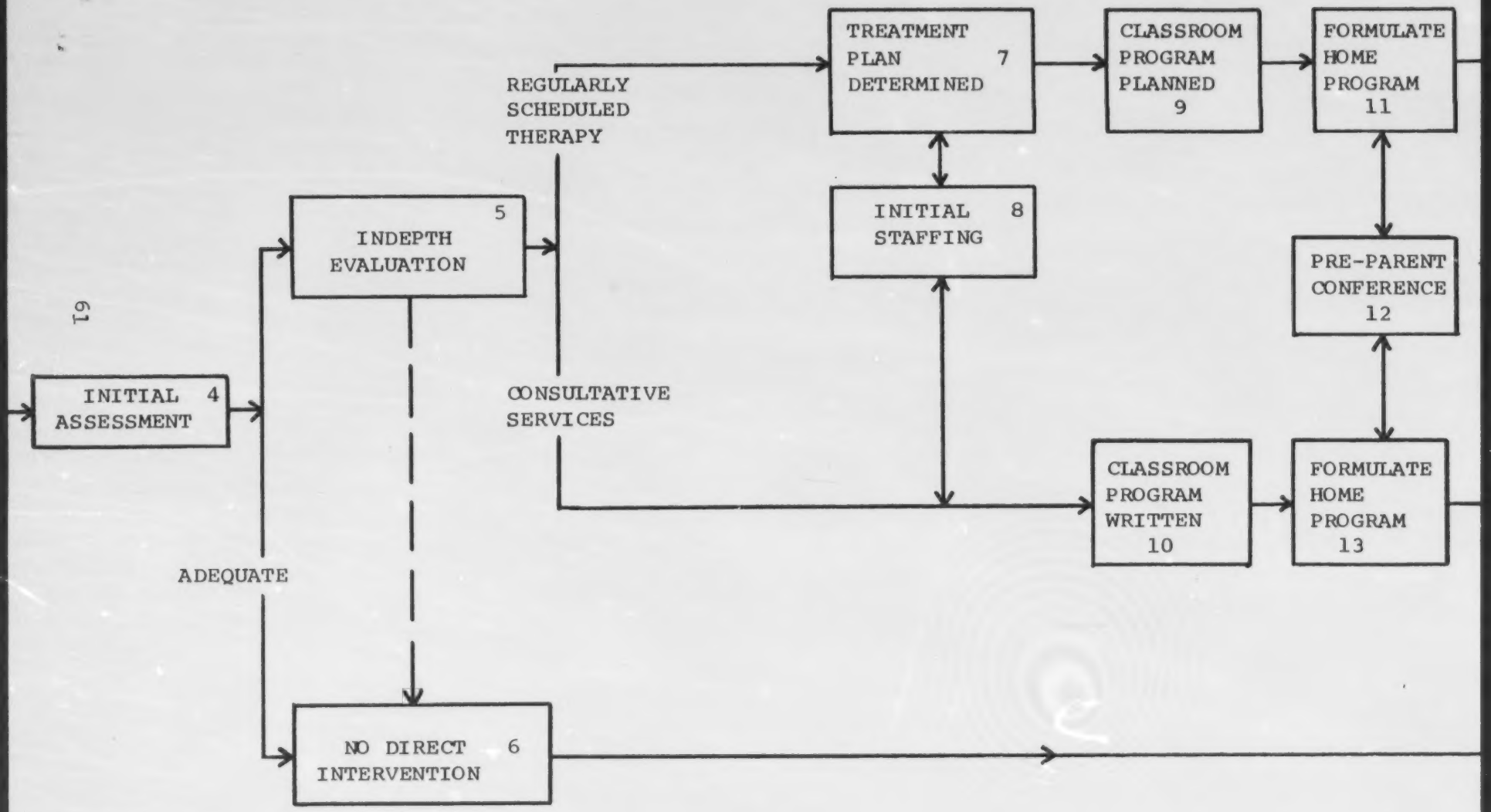


FIGURE 7

IMPLEMENTATION

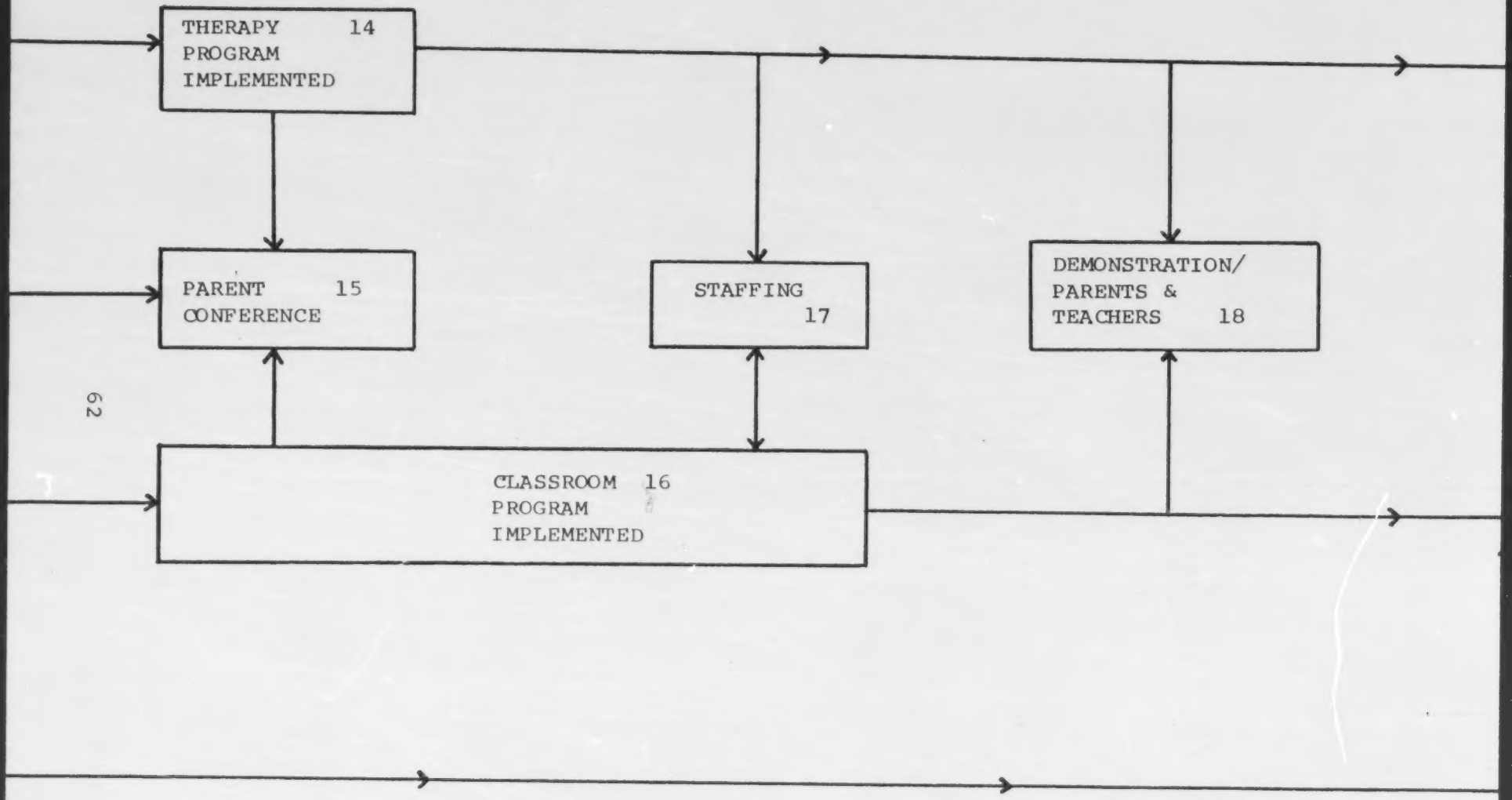
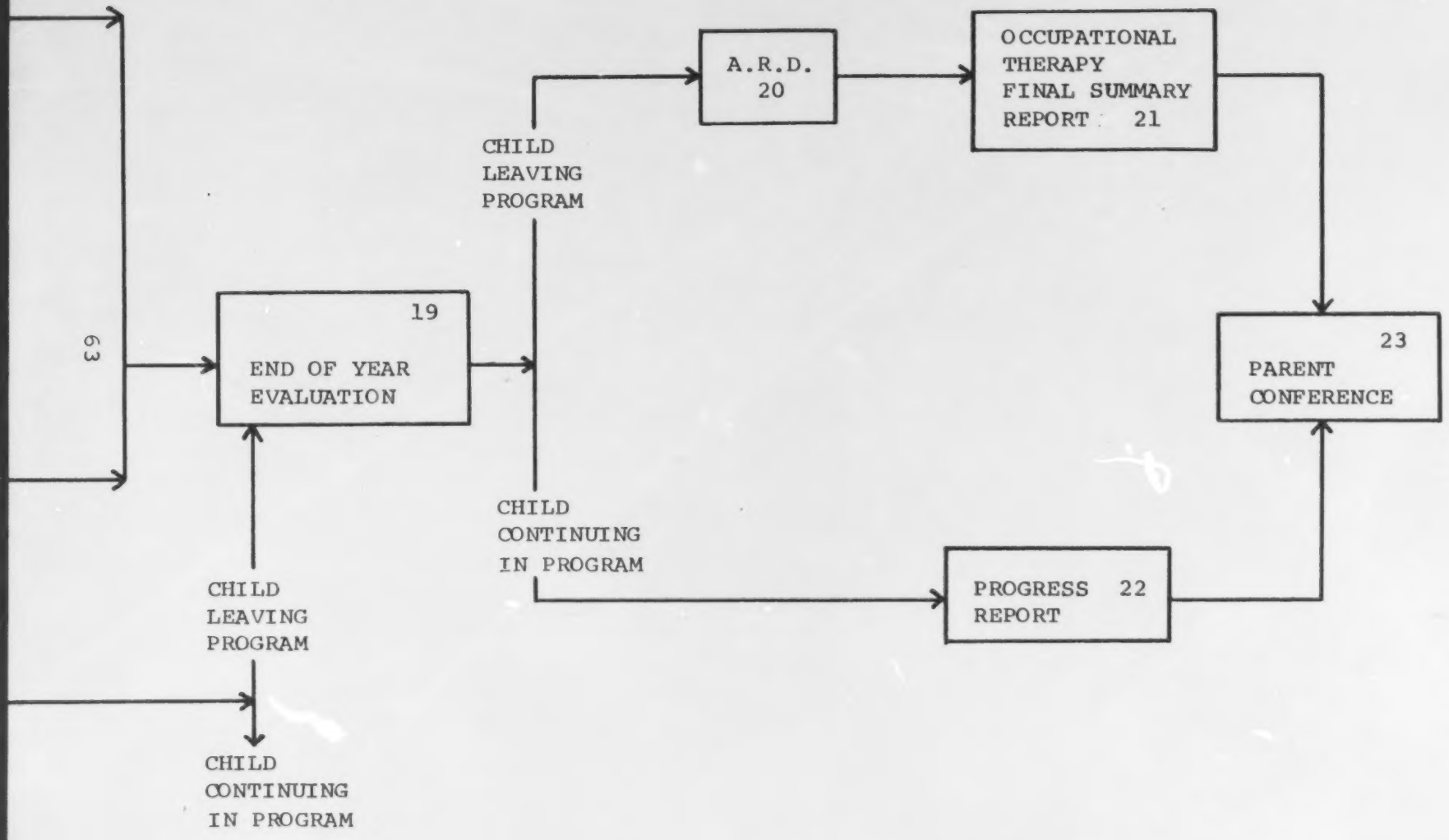


FIGURE 8

EVALUATION/REPORTING



Early Childhood Special Education
Occupational Therapy Evaluation

Name_____ Therapist_____

Date _____

DOB _____

CA _____

Activities of Daily Living

Balance

Gross Motor

Fine Motor

Reflexes

ATRN

Tonic labyrinthine

Labyrinthine righting

Optical righting

Equilibruim Reactions

Body Scheme

Muscle Tone

Perceptual-Motor

Sensory-Motor Integration

Dominance

eye _____ hand_____ foot _____

Comments

Reflex Testing Chart

Name_____ Reflex Level_____

Birthdate_____ Therapist_____

Date _____

Reflexes	+	-	Comments
1. Level One - Spinal:			
a. Flexor Withdrawal			0-2 mon.
b. Extensor Thrust			0-3 mon.
c. Crossed Extension			0-3 mon.
2. Level Two - Brain Stem			
a. Asymmetrical Tonic Neck			0-6 mon.
b. Symmetrical Tonic Neck			0-6 mon.
c. Tonic Labyrinthine - supine			0-4 mon.
prone			0-4 mon.
d. Associated Reactions			
e. Positive Supporting Reaction			3-8mon.
f. Negative Supporting Reaction			8 mon.
3. Level Three - Midbrain			
Righting Reactions:			
a. Neck Righting			0-6 mon.
b. Body Righting acting on the Body			6 mon.
c. Labyrinthine Righting acting on the head			(supine 2 mon.) 6 mon.
d. Optical Righting			2 mon.
e. Amphibian			6 mon.
4. Automatic Movement Reactions			
a. Moro Reflex			0-4 mon.
b. Landau Reflex			6-2½ yr.
c. Protective Extensor Thrust			6 mon.
5. Level Four - Cortical:			
Equilibrium Reactions:			
a. Prone-lying			6 mon.
b. Supine-lying			6 mon.
c. Four-foot kneeling			8 mon.
d. Sitting			10 mon.
e. Kneel-standing			15 mon.
f. Standing - hopping			15 mon.
dorsiflexion			15 mon.
see-saw			15 mon.
g. Simian posture			15 mon.

AUSTIN INDEPENDENT SCHOOL DISTRICT
Austin, Texas
Early Childhood Special Education
2710 Exposition

Dear Parent,

My name is _____ and I am a registered Occupational Therapist. I have been hired by the school district to work in the Early Childhood Program.

After a short observation period, I think that your child, _____, would benefit from occupational therapy in one or more of the areas stated on the enclosed referral sheet. However, before I can begin individual therapy I am required by law to have a physician's referral.

Please have the enclosed referral signed by your pediatrician or orthopedist and mailed directly to me at the above address. Some of the children in the program last year had referrals for treatment, but a yearly signed referral for this school year is necessary. I would appreciate your prompt action on this matter.

If you have any questions, please feel free to contact me at the school. I am looking forward to meeting with you and working with your child.

Sincerely,

_____, O.T.R.

Enclosure

AUSTIN INDEPENDENT SCHOOL DISTRICT
Early Childhood Special Education
Department of Occupational Therapy
Casis Elementary School 2710 Exposition Blvd.
Austin, Texas

REFERRAL FOR TREATMENT IN OCCUPATIONAL THERAPY

Name_____Birthdate_____

Referring Physican _____

Diagnosis _____

Degree of Disability and Body Parts Involved _____

_____

Medication _____

Check Treatment Indicated

__Basic Upper Extremity Functions
___stimulation techniques
___functional activities
___relation exercises
___resistive exercises
___active exercises
___passive exercises
___assistive apparatus - type _____

__Activities of Daily Living
___feeding
___dressing
___grooming

__Perceptual Motor Evaluation and Training
___motor planning
___body image
___tactle kinesthetic awareness
___intregration
___visual-motor

__Coordination
___fine coordination
___gross coordination
___eye-hand coordination

Additional Comments:_____

_____

Precautions or Restrictions:

_____

When should re-evaluation be done for possible changes in therapy _____

_____

Date _____Physican's Signature_____

Austin Independent School District
Early Childhood Special Education
Therapy Services Log
School Year _____

Speech Therapy

Therapist:

Occupational Therapy

Child's Name:_____

Services Provided:_____

Date Summary of Diagnostic:

Goals:

Recommendations to teachers:

Austin Independent School District
Early Childhood Special Education
Classroom Supplement
to Therapy

School Year _____

Speech Therapy

Therapist:

Occupational Therapy

Child's Name:_____

Austin Independent School District
Early Childhood Special Education
Therapy Report to Parents

Therapist:_____

Date:_____

Child's Name:_____

Follow-up:

Physical Therapy

Goals and Objectives

The goal of the physical therapy component is to provide services to children who have physical disabilities caused by disease or injury. Objectives for meeting this goal are:

1. To identify children requiring physical therapy services
2. To assess identified children to determine appropriate areas for remediation
3. To provide habilitation to identified children
4. To evaluate children's progress
5. To provide consultative services to staff, other professionals and parents.

Activities

The physical therapist provides services to children who have a physical disability. The primary goal of a child's physical therapy program is to improve motility and increase independence.

Identification of Children Requiring Physical Therapy Services

Identification of a child who requires physical therapy is usually made by a physician before the child comes to the AECSE Program. In some cases, a child is identified by a local agency serving physically handicapped children. Occasionally a child with a physical disability has not been identified at the time he enters the AECSE Program, and the physical therapist makes the identification.

In each case, a letter (see Appendix C) is sent to the child's parents informing them of the child's need for physical therapy. Enclosed in the letter is a Referral for Physical Therapy form (see Appendix C), which must be completed and signed by a physician (preferrably by an orthopedist if the child is being seen by one).

After the physical therapist receives the authorization from a physician, she schedules the child for assessment.

Assessment of Identified Children

A child's physical therapy program is determined by assessment of his assets and limitations. If a physician specifies a treatment plan for a child, the physical therapist follows this plan. If the physician does not specify a plan for the child, the physical therapist formulates a treatment plan based on the assessment battery she administers to the child and the general recommendations from the physician.

The assessment battery is usually administered to each child referred for physical therapy services, and consists of five basic tests. The physical therapist records the results of each test on a form describing that test. The assessment battery includes: a Reflex Testing Chart; a Test for Gross Motor Development; Voluntary Tests--Lower Extremity; Voluntary Tests-- Upper Extremity; and a Cerebral Palsy Assessment Chart -- Basic Motor Control (see Appendix C for samples of these forms).

When the physical therapist finishes the assessment on a child, she completes a P.T. Evaluation form (see Appendix C), in which she combines the information she has gathered in the five test areas. The P.T. Evaluation form serves as a therapy services plan for the child by outlining areas needing remediation. The physical therapist also completes a Physical Therapy Department form (see Appendix C), in which she summarizes the physician's recommendations and her treatment plan for the child.

The therapy schedule is also included on this form.

Habilitation of Identified Children

A child's specific therapy program is based on the results of the assessment and may include treatment in the one or more of the following areas: strengthening, stretching, gait training, balance, gross motor development, posture, and functional activities. Physical therapy services include direct therapy, recommendations for classroom activities and a plan for follow-through activities at home.

Children are usually scheduled for physical therapy in individual sessions since many children require specific treatment exercises that must be carried out only by the physical therapist. The sessions usually last thirty minutes, depending on the child's tolerance and strength. A child is generally scheduled for direct physical therapy services twice a week, depending on the therapist's caseload. In some cases, a child's classroom teachers implement a follow-through program in the room under the supervision of the physical therapist, thus providing carry-over of basic therapeutic plans.

Evaluation of Children's Progress

The physical therapist keeps a record of a child's performance on the Physical Therapy Progress Notes form (see Appendix C).

She records significant gains or problems and any recommendations for changes in a child's program.

At the end of the school year, the physical therapist evaluates a child's progress based on the P.T. Evaluation form. In a written report she describes the child's progress in each of the areas included on the P.T. Evaluation form, and makes recommendations concerning physical therapy services for the child. A copy of the final summary is sent to the referring physician.

Consultation Services

The physical therapist maintains close contact with teachers of children receiving physical therapy services to insure coordination of the therapy program and the classroom. She also provides consultative services to support staff and other professionals as needed. In many cases this is accomplished through conferences or written memos. When parents inform the physical therapist that a child is to have a recheck appointment with the orthopedist during the year, the therapist sends a progress note to the doctor.

Consultative services are provided to parents through conferences and/or demonstrations with the child. These services are necessary to effectively coordinate and carry out a physical therapy program for the child at home and at school.

Appendix C

AUSTIN INDEPENDENT SCHOOL DISTRICT
AUSTIN, TEXAS

Early Childhood Special Education
2710 Exposition Blvd.

Dear

Each school year a new Physical Therapy prescription must be signed by the child's doctor in order for your child to receive direct therapy. Please take the enclosed form to your doctor, preferably an orthopedist, and have him fill it out and return it to our address listed above. As soon as it is received your child will be scheduled for physical therapy.

Sincerely,

_____
Physical Therapist

Enclosure

AUSTIN INDEPENDENT SCHOOL DISTRICT
DEPARTMENT OF SPECIAL EDUCATION

Referral for Physical Therapy

Name _____ Date of Birth_____

Referring Physician_____

Diagnosis_____

Degree of Disability and Parts Involved_____

_____

Medication_____

Surgery_____

Check Treatment Indicated

Exercise

____Active
____Strengthening
____Muscle Re-education
____Coordination
____Range of Motion
____Other

Hydrotherapy

____Whirlpool
____Pool

Activities

____Visual Motor
____ADL
____Functional
____Coordination
____Other

Balance and Gait

____Balance
____Posture
____Gait Training

Additional Recommendations_____

Special Equipment_____

Precautions or Restrictions_____

When should re-evaluation be done for possible changes in therapy_____

_____

Date_____ Physican's Signature _____

Reflex Testing Chart

Name_____ Reflex Level_____

Birthdate_____ Therapist_____

Date _____

Reflexes	+	-	Comments
1. Level One - Spinal:			
a. Flexor Withdrawal			0-2 mon.
b. Extensor Thrust			0-3 mon.
c. Crossed Extension			0-3 mon.
2. Level Two - Brain Stem			
a. Asymmetrical Tonic Neck			0-6 mon.
b. Symmetrical Tonic Neck			0-6 mon.
c. Tonic Labyrinthine - supine			0-4 mon.
prone			0-4 mon.
d. Associated Reactions			
e. Positive Supporting Reaction			3-8mon.
f. Negative Supporting Reaction			8 mon.
3. Level Three - Midbrain			
Righting Reactions:			
a. Neck Righting			0-6 mon.
b. Body Righting acting on the Body			6 mon.
c. Labyrinthine Righting acting on the head			(supine 2 mon.) 6 mon.
d. Optical Righting			2 mon.
e. Amphibian			6 mon.
4. Automatic Movement Reactions			
a. Moro Reflex			0-4 mon.
b. Landau Reflex			6-2½ yr.
c. Protective Extensor Thrust			6 mon.
5. Level Four - Cortical:			
Equilibrium Reactions:			
a. Prone-lying			6 mon.
b. Supine-lying			6 mon.
c. Four-foot kneeling			8 mon.
d. Sitting			10 mon.
e. Kneel-standing			15 mon.
f. Standing - hopping			15 mon.
dorsiflexion			15 mon.
see-saw			15 mon.
g. Simian posture			15 mon.

Test for Gross Motor Development

Name_____ B.D._____ C.A._____ M.A. ___

Diagnosis_____ Test Date_____

Level	Activity	Comments
1-3 mos.	Lift head slightly	
	Head steady in supported sitting	
4 mos.	Lifts head 90-prone	
	Rolls to side	
	Rolls both ways	
	Pulled to sitting - assists	
6 mos.	Sits erect momentarily	
	Bears large part of weight standing	
	Sits steadily	
	Stands holding rail	
	Assumes hand and knee position	
	Crawling - pulls forward with extremities	
9 mos.	Pulls to feet beside furniture	
	Crawling - hands and knees reciprocally	
	Pivots in sitting	
	Walks sideways holding onto furniture	
	Stoops to pick up object and recover	
12 mos.	Walks one hand held	
	Assumes and maintains kneeling	
	Stands alone momentarily	
	Walks few steps alone	
	Stands independently	
	Creeps upstairs	
15 mos.	Runs stiffly and awkwardly	
	Squats in play	
18 mos.	Upstairs one hand held	
	Seats self in small chair	
	Down stairs one hand held	
	Upstairs holding rail	
2 yrs.	Walks and runs well	
	Downstairs holding rail	
	Kicks large Ball	
2½ yrs.	Jumps with both feet	
	Walks backward	
3 yrs.	Walks on tiptoe	
	Rides tricycle	
	Stands one foot momentarily (1 sec)	
	Upstairs alternate feet	
	Climbs ladder to slide and slides down alone	
4 yrs.	Swings self	
	Balances on one foot (5 sec)	
	Hop on one foot, either foot	
	Running broad jump 12"	
	Turns somersaults	
5 yrs.	Stands on one foot steadily	
	Down stairs alternate feet	
	Skip with alternate feet	
	Heel to toe	
	Jump backward	

Name _____

Diagnosis _____

VOLUNTARY TESTS
LOWER EXTREMITY

LEFT	DATE		RIGHT
		-Neck extensors	
		-Back extensors	
		-Quad Lumb. T12 L2	
		-Ant. Abd.,Upper T7-11	
		-Ant. Abd.,Lower T7-11	
		-Out. Rot.of hip L4-5S1-2	
	INFERIOR GLUTEAL NERVE	-Glut.Max. L5 S2	
	SUPERIOR GLUTEAL NERVE	-Glut.Med. L4-5 S1	
		-Tens.Fas.Latea L4-5 S1	
		-Glut.Min. L 4 S1	
	FEMORAL NERVE	-Hip Flexors L1-4	
		-Quad.Rect.Fem. L2-4	
		Vast.Med. L2-4	
		Vast.Lat. L2-4	
	OBPURATOR NERVE	-Adductors L2-4	
	SCIATIC NERVE	-Biceps Femoris L4-5S1-2	
		-Semitendinosus L4-5 S1	
		-Semimembranosus L4-5 S1	
	POST. TIBIAL NERVE	-Gastrocnemius L4 S2	
		-Soleus L4 S2	
		-Tib. Posticus L5 S2	
		-Flex.Dig.Long. L5 S2	
		-Flex.Hal.Long. L5 S2	
		-Lumbricales L5 S2	
	DEEP PERONEIA NERVE	-Tib. Anticua L4-5	
		-Ext.Dig.Long. L4 S1	
		-Ext.Dig.Brev. L4 S1	
		-Ext.Hal.Long. L4 S1	
	SUPERFICIAL PERONEAL NER.	-Per.Long&Brev. L5 S1	
	TESTED BY:		

VOLUNTARY TESTS UPPER EXTREMITY

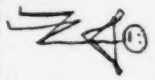
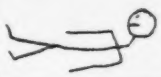
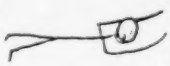
DATE: _____

LEFT		RIGHT
SPINAL ACCESSORY NERVE	-Sternocleidomastoid C 2,3	
	-Trapezius Upper C 2-4	
	Middle C 2-4	
	Lower C 2-4	
DORSAL SCAPULAR NERVE	-Rhomboids C 4-5	
LONG THORACIC NERVE	-Serratus Anterior C 5-7	
THORACO-DORSAL NERVE	-Latissimus Dorsi C 6-8	
LOWER SUBSCAPULAR NE.	-Teres Major C 5-7	
LAT. & MED.ANT.THOR.NERVES	-Pectoralis Major-Clav	
	-Stern	
SUBSCAPULAR NERVE	-Supraspinatus C 5-6	
	-Infraspinatus C 5	
MUSCULOCUTANEOUS NERVE	-Biceps Brachii C 5-6	
AXILLARY NERVE	-Deltoid-Ant. C 5-6	
	Mid. C 5-6	
	Post C 5-6	
	-Teres Major C 5-7	
RADIAL NERVE	-Triceps C 7-8	
	-Brachioradialis C 5-6	
	-Ext. Carp.Rad. L&B C 6-7	
	-Ext. Carp.ULN C 7	
	-Ext. Dig.Com-1 C 6	
	-2 C 6	
	-3 C 6	
	-4 C 6	
	-Abd.Pol. Longus C 7	
	-Ext.Pol. Brevis C 7	
	-Ext.Pol. Longus C 7	
MEDIAN NERVE	-Pronator Teres C6-8 T 1	
	-Flex.Carp.Rad. C 5-6	
	-Flex.Dig.Sub. C7-8 T 1	
	-Flex.Pol.Longus Ci T 1	
	-Flex. Dig.Prof.Lat. -1	
	-2	
	-Opponens Pol. C6-8 T1	
	-Abd.Pol.Brev. C 6-7	
	-Lumbricales Lat.-1C7-8 T 1	
	-2C7-8 T 1	
ULNER NERVE	-Flex.Carp. Uln. C 8 T 1	
	-Flex.Dig. Prof.Med-3	
	-4	
	-Lumbricales Med. -3	
	-4	
	-Adductor Policis C 8	
	-Abd.Min.Dig. C 8 T1	
	-Interossei,dorsal-1 C 8	
	-2 C 8	
	-3 C 8	
	-4 C 8	
	Palmar -1 C 8	
	Palmar -2 C 8	
	Palmar -3 C 8	

CEREBRAL PALSY ASSESSMENT CHART

BASIC MOTOR CONTROL

Name:_____ Birthdate:_____ Diagnosis:_____

Examiner: Test Postures and Movements		Name: Date	Remarks
Supine 1. Hips and knees fully, flexed, arms crossed, palms on shoulders			
2. Hips and knees fully flexed. (a) Extend right leg. (b) Extend left leg.		R. L.	
3. Head raised			
Prone 4. Arms extended beside head. Raise head in midposition.			
5. Arms extended beside body, palms down.			
6. (a) Flex right knee, hips extended. (b) Flex left knee, hips extended.		R. L.	
7. Trunk supported on forearms, upper trunk extended, face vertical.			
8. Trunk supported on hands with elbows and hips extended.			
Sitting erect 9. Soles of feet together hips flexed and externally rotated to at least 45°			
10. Knees extended and legs abducted; hips 90° - 100°.			

CEREBRAL PALSY ASSESSMENT CHART
BASIC MOTOR CONTROL

Name:_____ Diagnosis:_____ Birthdate:_____

Examiner: Test Postures and Movements		Name: Date	Remarks
11. Legs hanging over edge of table. (a) Extend right knee (b) Extend left knee		R. L.	
Kneeling 12. Back and neck straight (not hyperextended). (a) Weight on knees (b) Weight on hands		a b	
13. Side sitting, upper trunk erect, arms relaxed: (a) On right hip (b) On left hip		R. L.	
14. Kneeling upright, hips extended, head in mid-position, arms at sides.			
15. (a) Half kneeling: weight on right knee (b) Half kneeling: weight on left knee		R. L.	
Squatting 16. Heels down, toes not clawed, knees pointing in same directions toes, hips fully flexed, head in line with trunk.			
Standing and components of walking 17. Standing, correct alignment			
18. Pelvis and trunk aligned over forward leg. Both knees extended. (a) Right leg forward (b) Left leg forward		R. L.	

CEREBRAL PALSY ASSESSMENT CHART
BASIC MOTOR CONTROL

Name:_____ Diagnosis:_____ Birthdate:_____

Examiner:		Name:	
Test Postures and Movements		Date	Remarks
19. Bear weight on one leg in midstance. (a) Shift weight over right leg. (b) Shift weight over left leg.		R. L.	
20. Heel strike. Rear leg extended and externally rotated, heel down. Both knees straight. (a) Right heel strike (b) Left heel strike		R. L.	

P.T. Evaluation

Name_____ B.D._____

1. Diagnosis and background information

2. General Appearance

   Atrophy or hypertrophy
   Asymmetry
   Skin condition/circulation
   Deformity

3. Mental Status

   Alert
   Oriented in time and place
   Cooperation
   Attention
   Motivation
   Communication
   Gross vision and hearing

4. Range of Motion

   Active or passive

   What produces limitation

5. Muscle Function

   Isolated Muscle strength
   Endurance
   Strength limited to movement patterns

6. Sensation - Ability Perceive
   (touch, deep pressure, proprioception, temperature, pain)

7. Cortical Integration (perception)

   Two-point discrimination, awareness of body parts, spatial awareness

8. Reflexes and/or Reactions

   Amount of resistance to passive movement

   Associated reactions

   Postural reflexes

   Righting reflexes

   Balance reactions

9. Control of Fine and Gross Movement

   Direction
   Ability to stabilize

10. Posture

    Static positions
    Posture while moving

11. Gait (independence, endurance, balance, safety)

    Assisitive devices
    Personal assistance
    Moral support

12. Functional Activities (endurance, balance, safety & independence)

    Transfer activities

    Self care activities

CASIS SCHOOL

PHYSICAL THERAPY DEPARTMENT

Name_____ Birthdate_____ Grade___ Room ____

Telephone_____

Parent_____ Address_____ Teacher_____

Educational information_____

Referring Physician:_____ Date:_____

Diagnosis:_____

Physician's Recommendations:_____

Physical therapist's Findings and Treatment:_____

Schedule:_____

Month	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
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November																															
December																															

_____

Physical Therapist

CASIS SCHOOL

PHYSICAL THERAPY PROGRESS NOTES

NAME

ADDRESS B.D.

REFERRING PHYSICIAN PHONE

DIAGNOSIS DATE OF REFERRAL

The project presented or reported herein was performed pursuant to a Grant from the United States Office of Education, Department of Health Education and Welfare. However, the opinions expressed herein do not necessarily reflect the position or policy of the United States Office of Education; and no official endorsement by the United States Office of Education should be inferred.